Power Strips in Patient Care Areas

By David Stymiest, PE, CHFM, FASHE, CEM, GBE - DStymiest@ssr-inc.com

A subject that bears watching is the current concern about stand-alone power strips being used in General Patient Care Areas and Critical Patient Care Areas. ASHE/AHA Listserv users saw considerable traffic recently on this topic. The issue stems from a Centers of Medicare and Medicaid (CMS) document (Publication 100-07, Transmittal 27 dated August 17, 2007, entitled Revisions to Appendix PP – Guidance to Surveyors for Long Term Care Facilities) that includes the following excerpt: “Power strips may not be used as a substitute for adequate electrical outlets in a facility. Power strips may be used for a computer, monitor, and printer. Power strips are not designed to be used with medical devices in patient care areas.” Some hospitals are reporting that CMS hospital surveyors have used this LTC Facility guidance to cite them for using power strips (called “Relocatable Power Taps” in UL terminology) in General Patient Care Areas and Critical Patient Care Areas.

It appears that this issue arose because of Underwriters Laboratories’ (UL’s) concern that there are no listed power taps for patient care areas of health care facilities per UL product category “Relocatable Power Taps (XBYS).” UL stated in a March 1, 2008 posting on the International Association of Electrical Inspectors (IAEI) website www.iaei.org, “The use is restricted from these patient care areas because UL cannot control what is connected to the power taps which could result in leakage current that would be in excess of what is permitted for patient care areas of hospitals.” UL further stated that “UL does Classify complete system medical cart assemblies for use in hospitals under the product category “Medical Equipment (PIDF).” Those medical cart assemblies may contain a power tap as part of the tested assembly per UL 60601-1 Medical Electrical Equipment (previously UL 2601-1).” Interpreting UL’s statements, it appears that external equipment (that not already tested as part of the listing process) may not be plugged into the cart-mounted power strips.

Some hospitals are taking the risk assessment approach to this issue – that is recognizing that power strips, or relocatable power taps, are subject to failure just like any other device and therefore inventorying them and subjecting them to the same risk-based testing and maintenance regimens as outlets and medical devices.

Stay tuned to ASHE’s ongoing advocacy efforts – this subject is likely to continue to be part of those efforts due to its potential cost impact on America’s hospitals.

As always, regardless of the area in which such devices are used, facilities need to be aware of the total loading of devices plugged into them and ensure that the portable devices themselves, and the branch circuits that feed them, do not become overloaded. If power strips are presently being used, regardless of the area, high current-draw equipment should not be plugged into them.
Stair Identification Signs
By Michael L. Hawkins, CFSI, CHMT - MHawkins@ssr-inc.com


7.2.2.5.4* Stair Identification Signs
Stairs serving five or more stories shall be provided with signage within the enclosure at each floor landing. The signage shall indicate the story, the terminus of the top and bottom of the stair enclosure, and the identification of the stair enclosure. The signage also shall state the story of, and the direction to, exit discharge. The signage shall be inside the enclosure located approximately 5 feet (1.5 m) above the floor landing in a position that is readily visible when the door is in the open or closed position.

7.2.2.5.5 Egress Direction Signs
Wherever an enclosed stair requires travel in an upward direction to reach the level of exit discharge, signs with directional indicators indicating the direction to the level of exit discharge shall be provided at each floor level landing from which upward direction of travel is required. Such signage shall be readily visible when the door is in the open or closed position.
Exception No. 1: This requirement shall not apply where signs required by 7.2.2.5.4 are provided.
Exception No. 2: Stairs extending not more than one story below the level of exit discharge where the exit discharge is clearly obvious shall not be subject to this requirement.

Stairwell signage is extremely important not only for the evacuation of occupants but for the responding fire and rescue personnel. Please check those in your hospital to ensure that the needed and appropriate signs are in place.

Magnetic Locks Create Headroom Obstruction
By Robert Trotter, CBO, CFM - RTrotter@ssr-inc.com

As pictured in the example, magnetic locks installed to control access or egress often are located in a position that creates a headroom obstruction. According to section 7.2.1.2.2 of the NFPA 101®, Life Safety Code®, 2000 edition, “Projections into the required clear door opening width that are not less than 34 inches but that do not exceed 80 inches above the floor or ground shall be limited to the hinge side of each door opening and shall not exceed 4 inches.” This space allows for projections such as self-closing or automatic-closing devices, panic hardware and fire exit hardware. Projections exceeding 80 inches above the floor or ground are not limited.
Unusual Observations

By Robert Trotter, CBO, CFM - RTrotter@ssr-inc.com

Whether you complete your own life safety assessment for compliance with the Life Safety Code® or the work is performed by a third party, frequently an issue is discovered that is not described in the Statement of Conditions™. For the past several years we have been noting these issues as Unusual Observations. Starting in January 2009, as a result of The Joint Commission Standards Improvement Initiative, the new Life Safety Chapter incorporates an Element of Performance at the end of each individual standard to note other deficiencies. For example, under the Hospital Accreditation Program Standard LS.02.01.20 EP (32) states, “The hospital meets all other Life Safety Code means of egress requirements related to NFPA 101-2000: 18/19.2.” This Element of Performance gives you the latitude to create a Work Order or a Plan for Improvement (PFI) for any deficiency discovered that can not be associated with one of the Standard’s preceding Elements of Performance.

Regarding the example photograph, the Hospital Standard does offer Element of Performance (13) relative to the exit discharge and obstructions or impediments to the public way that may be acceptable for the landscape in the means egress. However, the full text and exceptions sends you NFPA 101-2000: 7.1.10.1 for means of egress reliability. Another key observation that may not be discernible in the photograph is the change in elevation in excess of 21 inches without a ramp or stair as required by NFPA 101-2000: 7.1.7.2. This would be an excellent example of when to cite noncompliance at LS.02.01.20 EP (32).

Noncombustible Sills for Fire Doors

By Robert Trotter, CBO, CFM - RTrotter@ssr-inc.com

Fire rated doors must be installed properly so that fire cannot spread below, around, or above the door. To minimize the risk for fire spread at the undercut of a fire door, NFPA 80, Standard for Fire Doors and Fire Windows, 1999 edition describes the requirements for sills. Section 1-11.2.1 states, “In buildings with noncombustible floors, special sill construction shall not be required, provided the floor structure is extended through the door opening.” Largely, healthcare occupancies have noncombustible floor construction and no special sill construction would be required. This means the example pictured would be compliant even though the carpet extends through the door opening. However, Section 1-11.2.3 states, “Combustible floor coverings shall not extend through openings protected by 3-hour rated fire protection door assemblies.”

In buildings with combustible floors or combustible floor coverings, special sill construction is required if the floor structure is extended through the door opening, as combustible floor construction is not permitted to extend through the door opening except door openings required to be protected by 20- or 30-minute doors. All sills must be constructed of noncombustible materials. Consult NFPA 80 for additional details regarding the arrangement of sills.
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For more information please contact:

Dean Samet, CHSP
800-545-6732
dsamet@ssr-inc.com
www.ssr-inc.com

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